STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

4500 10th Ave SE, Lacey, WA 98504

Statement of Deficiencies	Certification #: 2011178	Completion Date
Plan of Correction	Aacres WA, LLC (Snohomish Co)	August 17, 2021
Page 1 of 9		

You are required to be in compliance at all times with all laws and regulations to maintain your certification.

The department has completed data collection for the unannounced on-site certification evaluation on 8/16/2021 and 8/17/2021 of:

Aacres WA, LLC (Snohomish Co)
6505 218th St SW Ste. 9
Mountlake Terrace, WA 99224

The following sample was selected for review during the unannounced on-site visit: 6 of 23 current clients and 2 former clients.

The department staff that investigated the agency:

Karen Ritter, Field Evaluator Contractor
Jennifer Ahrens, Field Evaluator Contractor
Dianna Rapacz, Field Evaluator/ Contractor
Patricia Wieland, Field Evaluator Contractor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

As a result of the on-site visit(s) the department found that you are not in compliance with the laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services — Date: 8/23/21

I understand that to maintain certification, I must be in compliance with all the laws and regulations at all times.

Administrator (or Representative) — Date: 9/3/21

WAC 388-101D-0060 Policies and procedures.
(1) The service provider must develop, implement, and train staff on policies and procedures to address what staff must do:
(e) In emergent situations that may pose a danger or risk to the client or others, such as in the event of death or serious injury to a client;

This requirement was not met as evidenced by:
Based on observation, interview, and record review, the provider failed to ensure six of six sampled clients and their housemates were provided a safe living environment during the COVID-19 (coronavirus disease, a novel virus) pandemic by properly screening visitors, staff, and clients for COVID-19 symptoms as required by the provider's policy, and as mandated by the governor's Safe Start for Long-Term Care Plan and the Department of Health's Safe Start Recommendations and Requirements for Certified Residential Services and Supports Plan. This failure resulted in visitors and staff being admitted into client homes without the required screening requirements being completed, and clients not receiving daily temperature checks, and placed all clients served by the provider and their staff at risk of potential harm.

Findings included...

On 07/01/2021, the department issued a "Dear Provider Letter" providing Safe Start for Long-Term Care guidelines related to COVID-19 to all Supported Living providers in the state of Washington, which required providers to follow the governor's plan referenced therein.Review of the governor's "Safe Start for Long-Term Care" guidelines dated 07/01/2021 revealed providers must continue active screening regardless of vaccination status, actively screen residents/clients daily, actively screen 100% of all persons (residents, staff, visitors, etc.) entering/re-entering the facility/home including: temperature checks, questionnaire about symptoms and potential exposure, observation of any signs or symptoms, and maintain a screening log for 30 days.

Review on 08/17/2021 of the provider's "Emerging Infectious Disease Policy" revealed screening of visitors was required prior to entry and of staff prior to starting their shift, with results recorded on the "Covid-19 Direct Care Staff Sign-in Sheet," which directed staff to take their temperature and attest they had no symptoms of COVID-19. Further review found another form for staff to use for recording client temperatures, titled, "Twice Daily Temperature Checks".

Review of Person-Centered Service Plans, also known as Individual Support Plans, for Client 1, Client 2, Client 3, Client 4, Client 5, and Client 6, with effective dates of 04/16/2021, 05/01/2021, 05/01/2021, 11/30/2020, 02/16/2021, and 07/31/2021, respectively, revealed diagnoses of [redacted] and assistance was required with avoiding health and safety hazards.

Observation at Client 1's home on 08/16/2021 at 8:10am revealed Staff F working in the home did not screen the visiting Residential Care Services (RCS) Evaluator for potential signs and symptoms of COVID-19 nor request they complete the Screening Sign-in Sheet before entering the home.

Interview on 08/16/2021 at 8:10am with Staff F revealed visitors and staff no longer had to be

screened for COVID-19 symptoms. Staff F further stated clients were to be screened daily but staff were not required to document the data from the client screening.

Record review on 08/17/2021 revealed staff documented screening themselves only on 08/06/2021, 08/13/2021 and 08/16/2021 for the current month for COVID-19 prior to entering Client 1's home and documented the results on the provider's "COVID-19 Direct Care Staff Sign-In Sheet". There was no documentation showing staff had been taking client temperatures.

Record review on 08/17/2021 revealed there were no client COVID-19 daily screenings for Client 2.
Observation on 08/16/2021 revealed Staff G working in Client 3's home.

Record review on 08/16/2021 of "COVID-19 Direct Care Staff Sign-In Sheets" in Client 3's home revealed they were last filled out on 08/10/2021.

Interview on 08/16/2021 at 9:05am with Staff G revealed they took their own temperature daily but did not record it, and they had not received instruction from lead staff to do so. Staff G further stated the client's temperature was checked daily but not documented anywhere.

Observation at Client 4's home on 08/16/2021 at 1:50pm revealed Staff O and Staff P working in the home did not screen the visiting RCS Evaluator for potential signs and symptoms of COVID-19 nor request they complete the "Screening Sign-in Sheet" before entering the home. One hour later, at 2:55 pm, Staff P took temperatures of staff and the RCS Evaluator and had them fill out the Sign-in Sheet.

Interview on 08/16/2021 at 2:55pm revealed when asked about the timing of the screening, Staff P stated they had forgotten to do the check earlier at shift change and when the RCS Evaluator arrived.

Review of "COVID-19 Staff Sign-in Sheets" found not all staff for Client 4 coming on shift had filled out and signed it prior to coming on shift. Four staff signed on 08/12/2021, three staff signed on 08/13/2021, two staff signed on 08/14/2021, two staff signed on 08/15/2021, and three staff signed on 08/16/2021. There was no documentation staff had been taking client temperatures.

Observation at Client 5's home on 08/16/2021 at 11:50am revealed Staff Q and Staff R working in the home checked the temperature of the visiting RCS Evaluator, but did not ask screening questions regarding potential signs and symptoms of COVID-19 nor request they complete the "Screening Sign-in Sheet" before entering the home.

Interview on 08/16/2021 revealed, when the RCS Evaluator asked if staff had screening questions to ask, Staff Q stated they filled out the sheet, assuming the RCS Evaluator had self-screened before arrival.

Record review on 08/17/2021 revealed there were no client COVID-19 daily screenings for Client 6.

Interview on 08/16/2021 at 10:44am and on 08/17/2021 at 8:28am with Staff L (Executive

Director) revealed staff and visitors should be screened at client homes and the provider's office, and the provider was following the governor's Safe Start directives.

Interview on 08/17/2021 with Staff H (Area Director) at 11:40am revealed clients were not being screened daily for COVID-19 unless they had a pre-existing condition that increased their risk of contracting the virus.

Plan of Correction: Date Completed:

WAC 388-101D-0150 Client health services support. The service provider must provide instruction and/or support as identified in the individual support plan and as required in this chapter to assist the client with:
(1) Accessing health, mental health, and dental services;
(3) Maintaining health records;
(5) Monitoring medical treatment prescribed by health professionals;
(6) Communicating directly with health professionals when needed; and
(7) Receiving an annual physical and dental examination unless the appropriate medical professional gives a written exception.

This requirement was not met as evidenced by:
Based on observation, interview, and record review, the provider failed to ensure client health services support as required for two of six sampled clients (Client 2 and Client 3). This failure resulted in physician instructions not being followed for Client 2, and a referred consultation with a nutritionist not occurring and no instructions available to staff pertaining to symptoms of high or low blood glucose (sugar) for Client 3, and placed clients at risk of harm from preventable health concerns.

Findings included...

Review of Person-Centered Service Plans (PCSP) for Client 2 and Client 3, both with effective dates of 05/01/2021, revealed diagnoses of [redacted] and assistance was required with avoiding health and safety hazards, and obtaining healthcare services. Client 2's PCSP further indicated assistance was required with taking medications. Client 3's PCSP further indicated diagnosis of [redacted], and full physical assistance was required with maintaining a nutritious diet.

Record review on 08/16/2021 of Client 2's file revealed a physician's order dated 02/10/2020 instructing daily bowel movement (BM) tracking and if no BM in two days, administer Almacone Suspension 30 milliliters (mL) PRN (as needed). If no BM in three days, repeat Almacone PRN and administer Bisacodyl 5 milligrams (mg), and if no BM in four days, go to Urgent Care or Emergency Room for assessment. No BM-tracking documentation was found in Client 2's records.

Interview on 08/16/2021 at 3:59pm with Staff J (Team Coordinator) confirmed BM tracking was once completed but was not sure why or when the tracking ended. Staff J further explained they were on personal leave for the past four months and just returned to work a little over a week ago.

Further interview on 08/17/2021 with Staff H (Area Director) at 11:50am confirmed no BM tracking documentation from January 2021 to present was located for Client 2. Staff H stated Staff J kept up with documentation and the BM tracking must have been overlooked when Staff J was on leave, and staff shortages made things difficult.

Record review on 08/16/2021 of Client 3's current Medication Administration Record (MAR) revealed they were prescribed glimepiride 2mg daily and metformin 1000mg twice per day for diabetes.

Observation of Client 3's medication supply on 08/16/2021 at 8:35am revealed glimepiride and metformin were present.

Record review of Client 3's Positive Behavior Support Plan, dated 03/26/2021, on 08/16/2021 identified the client's potential to make unhealthy food choices.

Further record review revealed no documentation was available in the home outlining what a healthy diet would consist of for the client. A "Diabetes Protocol" for Client 3, signed by a physician on 04/22/2019, revealed Client 3's bloodglucose levels were checked twice per week and included instructions for action to take in the case of high or low readings. Client 3's record indicated their family member was responsible for checking blood glucose levels and implementing this protocol to prevent client refusal, and readings were recorded in an electronic document also accessible by the provider.

Interview on 08/16/2021 at 9:20am with Staff G working in Client 3's home revealed there were no instructions available to staff regarding a diabetic diet or dietary recommendations in any form, and they had not been instructed to follow any specific dietary guidelines. Staff G further stated staff were not trained on signs of high or low blood glucose, nor action to take in these circumstances.

Record review on 08/17/2021 revealed Client 3 was referred to a nutritionist by a physician on 06/25/2019. Further record review revealed no documentation of consultation with a nutritionist present.

Interview on 08/17/2021 at 10:20am with Staff H (Area Director) confirmed the recommended appointment with a nutritionist for Client 3 had not occurred, there were no instructions to staff regarding high or low blood glucose, and they were unsure why.

Plan of Correction: Date Completed:

WAC 388-101D-0170 Physical and safety requirements.
(2) The service provider must ensure that the following home safety requirements are met for each client unless otherwise specified in the client's individual support plan:
(a) A safe and healthy environment;
(b) Accessible telephone equipment and a list of emergency contact numbers;
(g) An accessible flashlight or other safe accessible light source in working condition; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the provider failed to ensure home safety requirements were met for one of six sampled clients (Client 3). This failure resulted in a working flashlight and telephone not being maintained, potential water damage in the client's home, and placed the all clients served by the provider in similar situations at risk of harm.

Findings included...

Review of Client 3's Person-Centered Service Plan, with an effective date of 05/01/2021, revealed diagnosis of [redacted] and support was required with avoiding health and safety hazards.

Observation at Client 3's home on 08/16/2021 at 8:44am revealed the strip of wall to the left of the bathtub appeared to be potentially water damaged. The area where the wall met the edge of the tub and baseboard was soft, peeling, and black- and rust-colored.

Further observation at 8:55am revealed the only flashlight available in the home was not functioning and its batteries were corroded.

Interview on 08/16/2021 at 8:44am with Staff G working in the home revealed the wall along the bathtub had been in the observed condition for approximately one month, and interview at 8:55am confirmed the non-functioning flashlight was the only flashlight in the home and replacement batteries were not available.

Further interview with Staff G at 9:05am revealed the landline phone in the home was not currently functioning due to the client recently damaging its wires when exhibiting behavior. Staff G reported they had their own cell phone on their person and the client did not express interest in using a phone.

Interview on 08/17/2021 at 10:20am with Staff H (Area Director) revealed the broken landline would be repaired or replaced and a backup provider cell phone would be placed in the home for staff as of the current day.

Record review on 08/17/2021 revealed the most recent provider "Home Checklists," completed 08/12/2021, did not address the bathroom wall damage nor the non-functioning flashlight and phone.

Interviews on 08/17/2021 at 10:28am with Staff H and at 10:35am with Staff I (Quality Assurance Specialist) confirmed the checklist did not cover the items of concern. Staff H further stated the provider was in the process of revising the content of their home safety reviews.

This is a repeat deficiency previously cited on 11/07/2019.

Plan of Correction: Date Completed:

WAC 388-101D-0240 Individual financial plan.
(1) The service provider must develop and implement an individual financial plan with client participation when the client's individual support plan:
(a) Identifies that the client needs support to manage funds; and
(b) Designates the service provider as responsible for that support; or
(c) Indicates the service provider manages any portion of the client's funds.
(2) The service provider must obtain signatures from the client and the client's legal representative on the individual financial plan.
(4) The service provider must review the individual financial plan with the client at least every twelve months.

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to ensure requirements for Individual Financial Plans (IFP) were met for three of six sampled clients (Client 1, Client 3, and Client 6). This failure resulted in outdated or unsigned IFPs, and placed all clients served by the provider in similar situations at risk of harm from financial supports implemented inaccurately or without consent.

Findings included...

Review of Person-Centered Service Plans, also known as Individual Support Plans, for Client 1, Client 3, and Client 6, with effective dates of 04/16/2021, 05/01/2021, and 07/31/2020, respectively, revealed diagnoses of [redacted] (Client 3), and support required with management of finances and protection from exploitation. The provider was Representative Payee (an entity which accepts disability or Social Security income payments for someone who is not capable of managing their own benefits) for Client 3 and Client 6; Client 1 had an outside Representative Payee and the provider managed cash on behalf of the client. Client 1, Client 3, and Client 6 had legal representatives.

Record review on 08/16/2021 revealed Client 1's IFP was dated 05/31/2021 and was not signed by their legal representative.

Interview on 08/16/2021 at 1:22pm with Staff M (Financial Specialist) confirmed the IFP was sent to the legal representative on 06/11/2021 and Staff M did follow up to ensure the legal representative had reviewed, signed, and returned Client 1's IFP.

Record review on 08/17/2021 revealed Client 3's current IFP was dated 03/01/2021 and was not signed by their legal representative.

Interview on 08/17/2021 at 2:45pm with Staff M confirmed Client 3's IFP had not been signed by their legal representative and the document had been mistakenly scanned into an electronic folder designated for signed documents, so they assumed it had been signed.

Record review on 08/17/2021 revealed Client 6's most recent IFP was dated 04/01/2020.

Interview on 08/17/2021 at 12:10pm with Staff I (Quality Assurance Specialist) confirmed

Client 6's IFP was last reviewed on 04/01/2020. Staff I further indicated they were not sure why it was overlooked and noted staffing shortages had made things difficult.

This is a repeat deficiency previously cited on 11/07/2019 and 03/05/2020.

Plan of Correction: Date Completed:

WAC 388-101D-0410 Positive behavior support plan.
(1) The service provider must develop, train to, and implement a written individualized positive behavior support plan for each client when:
(a) The client takes psychoactive medications to reduce challenging behavior or treat a mental illness currently interfering with the client's ability to have positive life experiences and form and maintain personal relationships; or
(b) Restrictive procedures, including physical restraints, identified in the residential services contract are planned or used.

This requirement was not met as evidenced by:
New WAC revision effective 6/26/21:
WAC 388-101D-0410 When is a positive behavior support plan required? (1) If a client requires a functional assessment under WAC 388-101D-0405, the provider must train to and implement a written individualized positive behavior support plan based on that functional assessment.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the provider failed to implement a Positive Behavior Support Plan (PBSP) for one of six sampled clients (Client 6) and the housemate of sampled Client 1 (non-sampled Client 7). This failure resulted in no window alarm in Client 6's bedroom and an inoperable door chime in the home of Client 7, and placed all clients served by the provider in similar situations and community at risk of harm.

Findings included...

Review of Person-Centered Service Plans, also known as Individual Support Plans, for Client 6 and Client 7, both with effective dates of 07/31/2021, revealed diagnoses of [redacted] and indicated both clients required high levels of behavior support, including extensive support in one or more areas of Exceptional Behavior Support Needs. Client 6 and Client 7 required a Functional Assessment per WAC (Washington Administrative Code) 388-101D-0405.

Record review on 08/16/2021 of Client 6's PBSP, dated 11/21/2020, revealed on 11/11/2020, Client 6 was found with the upper-half of their body out their second story bedroom window. The PBSP stated "alarm installed" to signal if the window was opened enough to allow Client 6's body to fit outside and "custom screens" made for the window.

Observation at Client 6's home on 08/16/2021 at 2:00pm revealed the client's bedroom window did not have an alarm or screen on it. The window had two locks: one in middle and one in the front. Both locks were easy to operate and working properly.

Interview on 08/16/2021 at 2:00pm with Staff K working in the home revealed an alarm or screen was never placed on the window. Staff K acknowledged the incident that occurred on 11/11/2020 and believed the items identified in the PBSP could have been a result of that incident. Staff K stated the only modification to the window was a second lock placed on the front of window frame.

Further interview on 08/17/2021 at 1:05pm with Staff I (Quality Assurance Specialist) confirmed the window restrictions were added to Client 6's PBSP and approved by their legal representative on 11/23/2020. Staff I reported they were not sure why the alarm and screen were not placed on the window and noted the staff who created the plan was no longer employed with the provider.

Record review on 08/16/2021 of Client 7's PBSP, dated 07/24/2020, revealed they were to have door chimes on the front and back door of their home to alert staff in case of an attempted elopement.

Observation at the home shared by Client 1 and Client 7 on 08/16/2021 at 9:50am revealed the chime on the back door was not working.

Interview on 08/16/2021 at 9:50am with Staff F working in the home confirmed the chime was not working.

Further interview on 08/16/2021 at 10:52am with Staff L (Executive Director) confirmed the chime on the back door should have been working.

Interview on 08/17/2021 at 8:14am with Staff H (Area Director) revealed the chimes were checked weekly and the last check was documented on 08/12/2021 by Staff N (Program Coordinator) who indicated the chimes were working.

This is a repeat deficiency previously cited on 11/07/2019.

Plan of Correction: Date Completed:

Plan of Correction

Agency Name	**Citation Date**
Aacres (Snohomish County)	9/17/2021
Submitted by	**Date of POC Submission**
Kendra Ellis	10/01/2021
X **Complaint Citation** ☐ **Certification Citation**	

Citation: WAC 388-101D- 0295 Medication Services General	
What *initial or immediate actions* were taken to address concerns affecting clients?	1. Health Services Director reviewed medications for Client 1 and 2 to ensure they are reflected accurately on the current MAR and is completing follow up with PCP's as needed. 2. Program Coordinators received training from the Health Services Director on checking in medications, which includes cross-referencing the Physician's Orders with the medications and MAR before delivering to the client home.
How will you apply the correction to all clients you support?	1. Program Coordinators and Team Coordinators will receive retraining on how to write non-cycle fill orders on the MAR. 2. Program Coordinators and Team Coordinators will receive training on completing weekly med box checks. Med box checks are completed weekly and when completed accurately, will identify the issues noted for WA 388-101D-0295. 3. DSPs will receive documented retraining on medication assistance, which includes following the 8 rights of medication assistance. 4. Program Coordinators will receive retraining on the Medication Error Questionnaire which assists in determining the root cause of the medication errors to support systemic changes when needed.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Area Director and State QI Director will ensure ongoing correction.

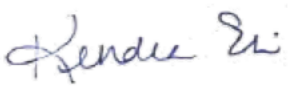
Date by which lasting correction will be achieved	11/1/2021
Additional Information	Enter any additional information you believe is pertinent such as intent to submit an IDR

Citation: WAC 388-101D-0315 Medication administration Nurse Delegation	
What *initial or immediate actions* were taken to address concerns affecting clients?	1. The Nurse Delegator for Client #2 assessed him as no longer needing delegation for all tasks except a transdermal PRN patch. Only delegated staff will apply the transdermal patch when needed. There is a delegation session scheduled to train additional DSP's to support client #2 with this task on 10/07/2021. 2. Only Nurse Delegated staff will assist Client #1 with his PRN inhaler when needed. The scheduler has been provided a list of staff who are delegated for this task. There is a delegation session scheduled to train additional DSP's to support client #1 with this task on 10/07/2021.
How will you apply the correction to all clients you support?	1. Program Coordinators and Team Coordinators will receive training on nurse delegation. This training will include how to determine if a client might need delegation, requesting an assessment for delegation, forms required to retain the nurse delegator and ensuring nurse delegated staff in the home. 2. Scheduling Coordinator will be provided a list of clients that require delegation, list of staff delegated to that client (including specific delegated tasks), and will ensure there are delegated staff on each shift. 3. Scheduling Coordinator will receive training on next steps if there is not a delegated staff available for a shift and how to ensure appropriate coverage. 4. DSPs will receive training on nurse delegation, including how to recognize the need for delegation, and what to do if they are not delegated and there is a delegated medication requiring support. 5. When Program Coordinators check in medications, either at end of the month, or when a new medication is prescribed, they will designate on the MAR that the medication is Nurse Delegated to ensure DSP's do not support a client with a delegated medication without prior training and instruction.

Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Area Director and State QI Director will ensure ongoing correction.
Date by which lasting correction will be achieved	11/1/2021
Additional Information	

Should you have any questions or need any additional information, please do not hesitate to contact me at 425-446-1789.

Sincerely,



Kendra Ellis
Executive Director